

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365287	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/23/2024
NAME OF PROVIDER OR SUPPLIER  Altercare of Cuyahoga Falls Ctr for Rehab & Nursin		STREET ADDRESS, CITY, STATE, ZIP CODE 2728 Bailey Rd Cuyahoga Falls, OH 44221	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</b></p> <p>Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure residents were either supervised during smoking breaks or residents signed out and left the facility premises prior to smoking independently. The facility also failed to ensure smoking materials, including cigarettes and lighters were kept in a secured area. This affected four residents (#56, #52, #57, and #46) reviewed for smoking and had the potential to affect 12 additional residents (#8, #12, #22, #28, #29, #32, #39, #44, #45, #49, #54, and #65) who were smokers residing at the facility. The facility census was 68.</p> <p>Findings include:</p> <p>1. Record review for Resident #56 revealed an admitted [DATE]. Diagnoses included muscle weakness, difficulty in walking, chronic respiratory failure, heart failure, insomnia, anxiety disorder, and nicotine dependence.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 was cognitively intact. Resident #56 used a walker, was independent with eating, required partial to moderate assistance with toileting, lower body dressing, and personal hygiene. Supervision was required with transfers and partial to moderate assistance with picking up an object off the floor. Resident #56 received oxygen therapy.</p> <p>Review of the physician orders revealed Resident #56 had an order for continuous oxygen at two liters per minute per nasal cannula dated 05/16/24 and increased to three liters per minute per nasal cannula on 07/23/24. The physician orders also included supervised smoker, dated 05/23/24.</p> <p>Review of the Smoking Risk Observation for Resident #56 dated 05/23/24 at 5:08 P.M. revealed Resident #56 was a safe smoker and able to understand and comply with the smoking policy safely. Initiate the plan of care.</p> <p>Review of the care plan dated 05/23/24 revealed Resident#56 can smoke independently by signing self out of facility. Resident #56 must follow the facility smoking policy and adhere to safety rules. Education will be provided to the resident in the event of non-adherence to the facility smoking policy. All smoking materials will be secured/locked in a designated location when not in use per facility policy. Resident #56 will smoke in facility designated area. Resident #56 will have supervision by a facility designated person throughout the smoking period.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview and observation on 07/22/24 at 11:00 A.M. with Resident #56 revealed Resident #56 was lying in bed. Resident #56 was wearing oxygen via nasal cannula at three liters per minute. Resident #56 confirmed he smoked cigarettes on a routine basis. Resident #56 had cigarettes and multiple lighters in his opened top drawer of his nightstand. Resident #56 revealed he was allowed to keep his own cigarettes and lighters and was permitted to go outside to smoke unsupervised any time he wanted. Resident #56 stated sometimes he took his portable oxygen tank out with him, but he would not turn it on. Resident #56 stated staff come and get his oxygen supplies when they see him out there.</p> <p>Observation on 07/22/24 at 11:54 A.M. revealed Resident #56 and Resident #8 were sitting on a bench near the front entrance of the facility. Resident #56 was smoking a cigarette and Resident #8 was sitting next to him. No staff were present. Resident #56 did not have his oxygen supplies with him. Resident #56 confirmed he smoked whenever he wanted independently as long as it was outside, and he carried his cigarettes and lighter with him. Resident #8 had his cigarettes and lighter sitting next to him and confirmed residents were allowed to smoke anytime they wanted and were permitted to keep their own cigarettes and lighters.</p> <p>Surveyor spoke to the Director of Nursing (DON) on 07/22/24 at 12:00 P.M. to verify Residents #56 and #8 smoking at the front entrance of the facility. The DON revealed all (16) residents residing at the facility who smoked cigarettes were independent smokers, and they did not require staff to supervise them, including Resident #56. The DON stated residents were supposed to only smoke in the courtyard, but they were often noncompliant, smoking in the front of the building, at the side, and out back. The DON stated she wrote care plans for the resident's noncompliance, but they had their rights.</p> <p>Interview on 07/22/24 between 12:40 P.M. and 1:30 P.M. with Licensed Practical Nurses (LPNs) #151, #111 and State tested Nurse Aide (STNA) #175 revealed all residents who smoked were independent smokers and could go outside and smoke at any time they wanted. Residents who smoked were allowed to keep their cigarettes and lighters with them at all times. LPN #151 revealed sometimes Resident #56 took his oxygen supplies out with him to smoke, but the oxygen was shut off. LPN #151 revealed the staff would go outside and retrieve his oxygen supplies when he did take them with him.</p> <p>Interview on 07/23/24 at 7:38 A.M. with LPN #150 revealed residents smoke when they want, and they keep their cigarettes and lighters with them. No residents were required to wear smoking aprons, and there were no residents who had burns or injuries as far as she knew.</p> <p>2. Record review for Resident #52 revealed an admitted [DATE]. Diagnoses included muscle weakness, difficulty in walking, chronic obstructive pulmonary disease, repeated falls, and combined forms of age-related cataracts bilateral.</p> <p>Review of the admission MDS assessment dated [DATE] revealed Resident #52 was cognitively intact. Resident #52 required setup or clean up assistance with eating, and supervision with grooming and personal hygiene.</p> <p>Review of the Smoking Risk Observation for Resident #52 dated 07/22/24 at 1:02 P.M. revealed Resident #52 was a safe smoker and able to understand and comply with the smoking policy safely. Continue with the plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the care plan for Resident #52 dated 04/16/24 revealed Resident #52 was able to smoke independently by signing self out of facility. Resident #52 must follow facility smoking policy and adhere to safety rules. Education will be provided to the resident in the event of non-adherence to facility smoking policy. All smoking materials will be secured/locked in a designated location when not in use per facility policy. Resident #52 will smoke in facility designated area. Resident #52 will have supervision by a facility designated person throughout the smoking period.</p> <p>Observation on 07/22/24 at 11:31 A.M. revealed Resident #52 was sitting in the courtyard smoking independently, no staff were present. Observed Resident #52 carried his own pack of cigarettes and lighter. Resident #52 revealed he always had his own cigarettes and lighter, he never had to turn them in to anybody and he was able to go outside and smoke independently whenever he wanted.</p> <p>3. Record review for Resident #57 revealed an admitted [DATE]. Diagnoses include chronic obstructive pulmonary disease, muscle weakness, and abnormalities of gait and mobility.</p> <p>Review of the admission MDS assessment for Resident#57 dated 07/08/24 revealed Resident #57 was moderately cognitively impaired. Resident #57 required setup or clean up assistance with eating, partial to moderate assistance with personal hygiene and picking up small objects from the floor.</p> <p>Review of the Smoking Risk Observation for Resident #57 dated 07/22/24 at 12:07 P.M. revealed Resident #57 was a safe smoker and able to understand and comply with the smoking policy safely. Initiate the plan of care.</p> <p>Review of the care plan for Resident #57 dated 07/22/24 revealed Resident #57 was able to smoke independently by signing self out of facility. Resident #57 must follow the facility smoking policy and adhere to the safety rules. Education will be provided to the resident in the event of non-adherence to the facility smoking policy. All smoking materials will be secured/locked in a designated location when not in use per facility policy. Resident #57 will smoke in the facility designated area. Resident 357 will have supervision by a facility designated person throughout smoking period.</p> <p>Observation on 07/23/24 at 8:36 A.M. revealed Resident #57 was smoking in the courtyard independently. No staff were present. Resident #57 had his cigarettes and lighter with him. Resident #57 stated he was able to smoke independently and unsupervised whenever he wanted.</p> <p>4. Record review for Resident #46 revealed an admitted [DATE]. Diagnoses included flaccid hemiplegia affecting left nondominant side, chronic obstructive pulmonary disease, anxiety disorder, dementia, epilepsy, restless leg syndrome, traumatic brain injury, lack of coordination and weakness, and need for assistance with personal care.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #46 was cognitively intact. Resident #46 had impairment to upper and lower extremities and used a wheelchair for mobility. Resident #46 required set up/clean up assistance with eating and personal hygiene.</p> <p>Review of the Smoking Risk Observation for Resident #46 dated 07/22/24 at 1:00 P.M. revealed Resident #46 was a safe smoker and able to understand and comply with the smoking policy safely. Continue the plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the care plan for Resident #46 dated 06/28/24 revealed Resident #46 was able to smoke independently by signing self out of facility. Resident #46 must follow the facility smoking policy and adhere to the safety rules. Education will be provided to the resident in the event of non-adherence to the facility smoking policy. All smoking materials will be secured/locked in a designated location when not in use per facility policy. Resident #46 will smoke in the facility designated area. Resident #46 will have supervision by a facility designated person throughout smoking period.</p> <p>Observation on 07/23/24 at 8:39 A.M. revealed Resident #46 was smoking in the courtyard independently. No staff were present. There was a metal box on a post marked smoking blanket. The box was empty. Resident #46 had his cigarettes and lighter with him. Resident #46 revealed he was able to smoke independently and unsupervised whenever he wanted.</p> <p>Interview on 07/23/24 at 8:43 A.M. and 9:59 A.M. with the DON confirmed there were 16 residents residing at the facility who smoked cigarettes, and all 16 were assessed for smoking and determined safe to be independent smokers. The DON confirmed residents did not require staff to be present while they were smoking, and residents were not required to sign out of the facility before they smoke independently because they were determined safe according to the smoking assessment. The residents were not supposed to keep their cigarettes and lighters with them when they were not in the designated smoking area and confirmed they did because if she or the staff took them, they would just get more. Th DON verified that the box that was to have a smoking blanket in it was empty, and she would try to find where it went. Review of the resident care plans with the DON, revealed she was unaware residents care plans included residents may smoke independently by signing self out of facility, and the resident will have supervision by a facility designated person throughout smoking period. Review of the facility policy with the DON, confirmed there were no smoking times or a smoking policy posted in the facility. There was no documentation in the medical records reviewed for the previous three months for Resident #56, #52, #57, or #46 regarding additional education provided related to noncompliance with the smoking care plan or facility policy for smoking.</p> <p>Interview on 07/23/24 at 9:45 A.M. with Lead Receptionist #108 confirmed the resident sign in and out book was located at the front desk where she was also located. Lead Receptionist #108 revealed residents do not sign out in the book to leave the premises to smoke independently because they don't need to leave the premises, they were permitted to smoke independently without leaving the premises.</p> <p>Review of the facility policy titled Resident Smoking Policy, updated 12/2017, revealed it is the policy of this facility to provide an environment to allow those residents, who wish to smoke, the opportunity to do so in an environment that provides optimal safety for all residents, visitors, volunteers and staff. The smoking policy will be posted in a designated area such as on a bulletin board located in a common or high traffic area. Smoking will be permitted in the designated area only and at the designated smoking times. A 15-minute smoking session will be provided at each designated smoking time. Residents who wish to smoke at times other than the designated smoking times, may do so by signing themselves out of the facility. All residents will be provided supervision by a staff member in the designated smoking area. Smoking supplies which may include but may not be limited to lighters, matches, cigarettes shall not be retained by the resident. Such supplies will be maintained in the designated area accessible only by staff.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00155906.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42011</p> <p>Based on observation, interview, record review, and review of the facility policy, the facility failed to provide thorough incontinence care for Resident #45. This affected one resident (#45) of one resident observed for incontinence care. The facility census was 68.</p> <p>Findings include:</p> <p>Record review for Resident #45 revealed an admitted [DATE]. Diagnoses included diffuse traumatic brain injury, hemiplegia affecting right dominant side, and muscle weakness.</p> <p>Review of the annual Minimum data Set (MDS) assessment dated [DATE] revealed Resident #45 had severe cognitive impairment. Resident #45 required partial/moderate assistance with toileting and substantial maximum assistance with personal hygiene. Resident #45 was always incontinent of bowel and bladder.</p> <p>Review of the care plan dated 06/06/23 revealed Resident #45 was incontinent of bowel and bladder and was at risk for altered dignity, skin breakdown and urinary tract infection (UTI). Interventions included checking and providing incontinence care as needed and applying moisture barrier cream after each incontinent episode.</p> <p>Observation on 07/23/24 at 10:52 A.M. of incontinence care for Resident #45 with State tested Nurse Aide (STNA) #148 revealed Resident #45's brief was visibly saturated. STNA #148 removed the front of the brief. STNA #148 then washed, rinsed, and dried Resident #45's peri area, rolled Resident #45 on his side. The bed pad under the soiled brief that Resident #45 was lying on was also visibly saturated. STNA #148 then placed a new brief and bed pad under Resident #45 then rolled Resident #45 back and secured the brief. STNA #148 confirmed the bed pad under Resident #48 was saturated with urine and confirmed she never washed or cleaned Resident #45's buttocks area during incontinence care nor applied moisture barrier cream.</p> <p>Interview on 07/23/24 at 11:15 A.M. with the Director of Nursing (DON) revealed during incontinence care with residents, even if the resident was only incontinent of urine, the staff were expected to cleanse both the peri area and buttocks area of the residents to ensure the skin was cleansed of urine.</p> <p>Review of the undated facility policy titled, Perineal Care included it is the facility policy to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the residents skin condition. Steps in the procedure for a male resident included to also wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155212.</p>		